

00-15056

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the physician's signature after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified directly.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
THOMAS Jefferson Baker		August 7 1986		6:15 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	White	10 31 99	86 YRS.	TALBOT MD.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Arkansas	U.S.A.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE, SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
EASTON	Memorial Hospital	Gen Manager	Transfer Co.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. COUNTY	13d. CITY OR TOWN	13e. INSIDE CITY LIMITS?	13f. STREET ADDRESS / ZIP CODE
Maryland	Queen Anne	Queenstown	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Rt 1 Box 103 21658
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
Martin R. Baker	Elizabeth Wilkerson	21658			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
Yes	WW I	Raymond G. Tarrant Rt 1 Box 103 Queenstown MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic lobe pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u> 23 weeks					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Acute coronary artery disease &amp; CHF</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2, OR PART 3)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION (CITY OR TOWN, COUNTY, STATE)			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/7</u> <u>86</u> to <u>8/7</u> <u>86</u> , that (I) (we) last saw the deceased alive on <u>8/7</u> <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)	22b. DATE SIGNED <u>8/7/86</u>				
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS		23c. DATE SIGNED	
ALBERT T. DAWKINS JR		Rt 3 Box 127 EASTON MARYLAND 21601		8/7/86	
23d. BURIAL, CREMATION, REMOVAL (SPECIFY)	23e. DATE	23f. NAME OF CEMETERY OR CREMATORY	23g. LOCATION CITY OR TOWN	23h. COUNTY	23i. STATE
Burial	8/11/86	National Memorial Pk	Falls Church	Fairfax	VA
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D BY REGISTRAR	
Newnam Funeral Home		Easton MD 21601		AUG 12 1986	

TABLE



11/11/11

00-17653

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Verna H. Black</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 23 86</b>		2b. HOUR <b>450 PM</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 10 38</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b>		
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>EASTON MEMORIAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot County MD</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Health Care</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Goldsboro</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt. 1 Box 212 21636</b>				
FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Hendricks</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Verna Fryer</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>169-30-3001</b>		17. INFORMANT <b>Mr. Robert Black</b>		
				ADDRESS <b>Goldsboro, MD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BREAST CANCER</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>13 mo</b>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <b>8-23</b> , 19 <b>85</b> , to <b>8-23</b> , 19 <b>85</b> that (we) last saw the deceased alive on <b>8-23</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Stephen P. Carney</b>				22c. DATE SIGNED <b>8-25-86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen P. Carney, M.D.</b>				22e. ADDRESS <b>Easton, Md. 21601</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>8-27-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro Cemetery</b>		
24. FUNERAL DIRECTOR NAME <b>Boulais Funeral Home</b>		ADDRESS <b>Greensboro, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 02 1986</b>		
				25b. REGISTRAR'S SIGNATURE <b>Laurel J. [Signature]</b>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP \_\_\_\_\_

00-15823



COTTON FIBRE

00-81807

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23997  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
		ESTIMATED <input checked="" type="checkbox"/> MATED <input type="checkbox"/>		8 4 1986		3 07 AM	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST					
maurice JR Bolden II							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
male	Black	8 4 86	Inf.			8 4 1986 3 08 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MD		U.S.				Talbot MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton		Memorial					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD		Caroline		Ridgely		P.O. Box 510 Ridgely, MD	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
maurice JR Bolden		Dawn Evetta Daniels					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Premature labor</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost: _____							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED	
JUDITH GIESKE		MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
8/4/86		8/4/86					
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				AUG 27 1986		John A. Davidson	



4  
0-16557

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

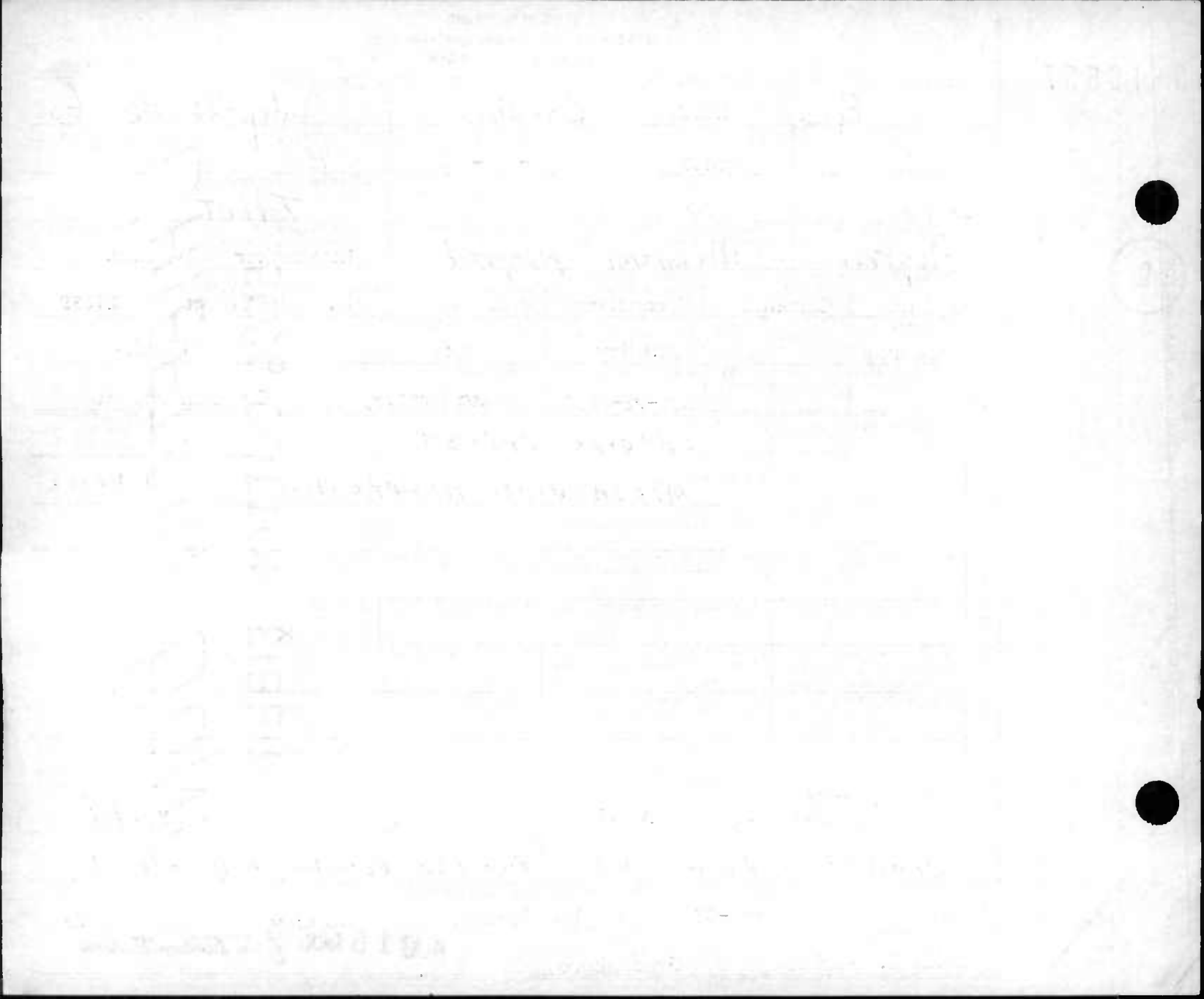
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 23998								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Eva Edith Bradley</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>July-28-1986</i>					2b. HOUR <i>6p.m.</i>
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10-3-09</i>		6. AGE (IN YEARS, LAST BIRTHDAY) <i>76</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.				
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>homemaker.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>home</i>		
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Caroline</i>		13c. CITY OR TOWN <i>Greensboro</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>N. Main Street 21639</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Bradley</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Myra Fleming</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>		16b. SOCIAL SECURITY NO. <i>220-03-6209</i>		17. INFORMANT ADDRESS <i>Bette Bradley Greensboro, MD</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <i>MYOCARDIAL INFARCTION</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2 hours</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>J. Corwin M.D.</i>				DEGREE <i>M.D.</i>				22c. DATE SIGNED <i>8/6/86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JAMES E. CORWIN M.D.</i>				22e. ADDRESS <i>Box 660, DENTON, MD 21629</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>8-1-86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Busick Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Barclay QA MD</i>				
24. FUNERAL DIRECTOR NAME ADDRESS <i>John E. Boulais Greensboro, MD</i>										

MEDICAL CERTIFICATION

AUG 18 1986  
REGISTRAR'S SIGNATURE  
*John Boulais*





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

23999

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Charlesia M Brice</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8 21 86</b>				2b. HOUR <b>1125 P</b>	
3. SEX <b>Female</b>		4. RACE <b>Blk</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 4 11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.			
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>R#3 Box 385</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>md</b>		13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Easton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>R#3 Box 385 21601</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Norman Russell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>M. Indie Chase</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>220-54-7649</b>		17. INFORMANT ADDRESS <b>House Brice</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>monition</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>severe rheumatoid arthritis</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 86</b> to <b>present</b> , that (I) (we) last saw the deceased alive on <b>Oct 27 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>8-28-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. Sanchez</b>				22e. ADDRESS <b>322 Commerce Dr Barton</b>					
23a. BURIAL, CREMATION, REMOVAL <b>cremation</b>		23b. DATE <b>8/26/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ivy town</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton TA. md</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>George H. Washburn Easton md</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-17884

Handwritten text, mostly illegible due to fading and bleed-through. The text appears to be organized into several paragraphs or sections, possibly separated by horizontal lines. Some words are more legible than others, but the overall content is difficult to discern.

00-81810

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24000  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William E. BROWN</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8 22 86</i>		2b. HOUR <i>5<sup>53</sup> P.M.</i>		
3. SEX <b>Male</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <i>6 10 04</i>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot County</i> MD	
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Easton Memorial</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Wildlife Management</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Greensboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>200-10-3969A</b>	
17. INFORMANT ADDRESS <b>Dept. of Social Services</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic obstructive Lung Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Seizure Disorder</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J. Corwin</i>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/22/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. CORWIN</b>		22e. ADDRESS <b>PO BOX 660, DENTON MD 21629</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>8-23-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Delmarva Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lewes Sussex Del.</b>	
24. FUNERAL DIRECTOR NAME <b>John E. Boulais</b>		ADDRESS <b>Greensboro, Md. 21639</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 02 1986</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP \_\_\_\_\_

01810-00

RECEIVED



UNITED STATES CUSTOMS

NEW YORK

00-16069

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a 72-hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24001  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST William Goldie Butler		2a. DATE OF DEATH MONTH DAY YEAR 08 16 86		2b. HOUR 6:50 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 04 02 16		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Cordova		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt 1 Box 66G		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Cordova		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 1 Box 66G 21625	
14. FATHER'S NAME FIRST MIDDLE LAST William A. Butler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucinda		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 220-34-9495		17. INFORMANT ADDRESS Robert Greathouse Rt 1 Box 66G Cordova MD	
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/05	
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>ASCD</u>							
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE		21i. LOCATION STREET CITY OR TOWN COUNTY STATE		21j. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>7/25</u> 19 <u>86</u> to <u>8/16</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did not see the body after death).		22b. SIGNATURE <u>Donald T. Lewers</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald T. Lewers, M.D.		22e. ADDRESS Dutchman's Lane Easton MD 21601		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/19/86		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Hillsboro Caroline MD		23e. LOCATION CITY OR TOWN COUNTY STATE Hillsboro Caroline MD		23f. LOCATION CITY OR TOWN COUNTY STATE Hillsboro Caroline MD		23g. LOCATION CITY OR TOWN COUNTY STATE Hillsboro Caroline MD		23h. LOCATION CITY OR TOWN COUNTY STATE Hillsboro Caroline MD	
24. FUNERAL DIRECTOR NAME ADDRESS Newnam Funeral Home Easton MD 21601		25a. DATE REC'D. BY REGISTRAR AUG 21 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>		25c. REGISTRAR'S SIGNATURE <u>John Davidson</u>		25d. REGISTRAR'S SIGNATURE <u>John Davidson</u>	

10001-0

6  
00-16991FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

24002

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM ANDREW CARRIER, SR.			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8 31 1986		2b. HOUR 5:54 P.M.	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Jan. 9, 1925	6. AGE (IN YEARS) LAST BIRTHDAY 61 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8/31/86
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12a. USUAL OCCUPATION (TYPE OF WORK) SALESMAN		12b. KIND OF BUSINESS HEARING AID SPECIALIST
13a. STATE MARYLAND		13b. COUNTY WICOMICO		13c. CITY OR TOWN SALISBURY		13d. STREET ADDRESS 21801 DEER HARBOR DR. MD
14. FATHER'S NAME MARSHALL HUGHES CARRIER, SR.			15. MOTHER'S MAIDEN NAME LOUISE WOLF			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 215 28 5314		17. INFORMANT DEER HARBOR DR. MYRNA BAKER CARRIER SALISBURY, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE R. Paul Wroth		M.D.		MEDICAL EXAMINER		DATE SIGNED 9-1-86
EXAMINER'S NAME (TYPE OR PRINT) R. Paul Wroth		ADDRESS Easton Memorial Hospital, Easton, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/3/86		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK BERLIN WORCESTER MD		
24. FUNERAL DIRECTOR NAME W. Kirk Burbage		ADDRESS 108 William St. Berlin MD 21811		25a. DATE REC'D. BY REGISTRAR SEP 2 1986		25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

George and Victoria Smith

1/10/11



00-15772

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24003  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret Hope Casson			2a. DATE OF DEATH MONTH DAY YEAR August 11, 1986			2b. HOUR 9:05 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 05 31 14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 417 S. Washington St		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST E. Russell Casson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Davis		13e. STREET ADDRESS / ZIP CODE 417 S. Washington St 21601			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-8241		17. INFORMANT ADDRESS Elinor Casson 417 S Washongton St Easton			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BREAST CANCER</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-22</u> , 19 <u>83</u> , to <u>8-11</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>7-30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen P. Carney</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/12/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.				22e. ADDRESS Dutchman's Lane Easton MD 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/14/86		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot MD	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Esaton MD 21601		25a. DATE REC'D BY REGISTRAR AUG 18 1986	
				25b. REGISTRAR'S SIGNATURE <i>J. M. Davidson</i>			

STARTED

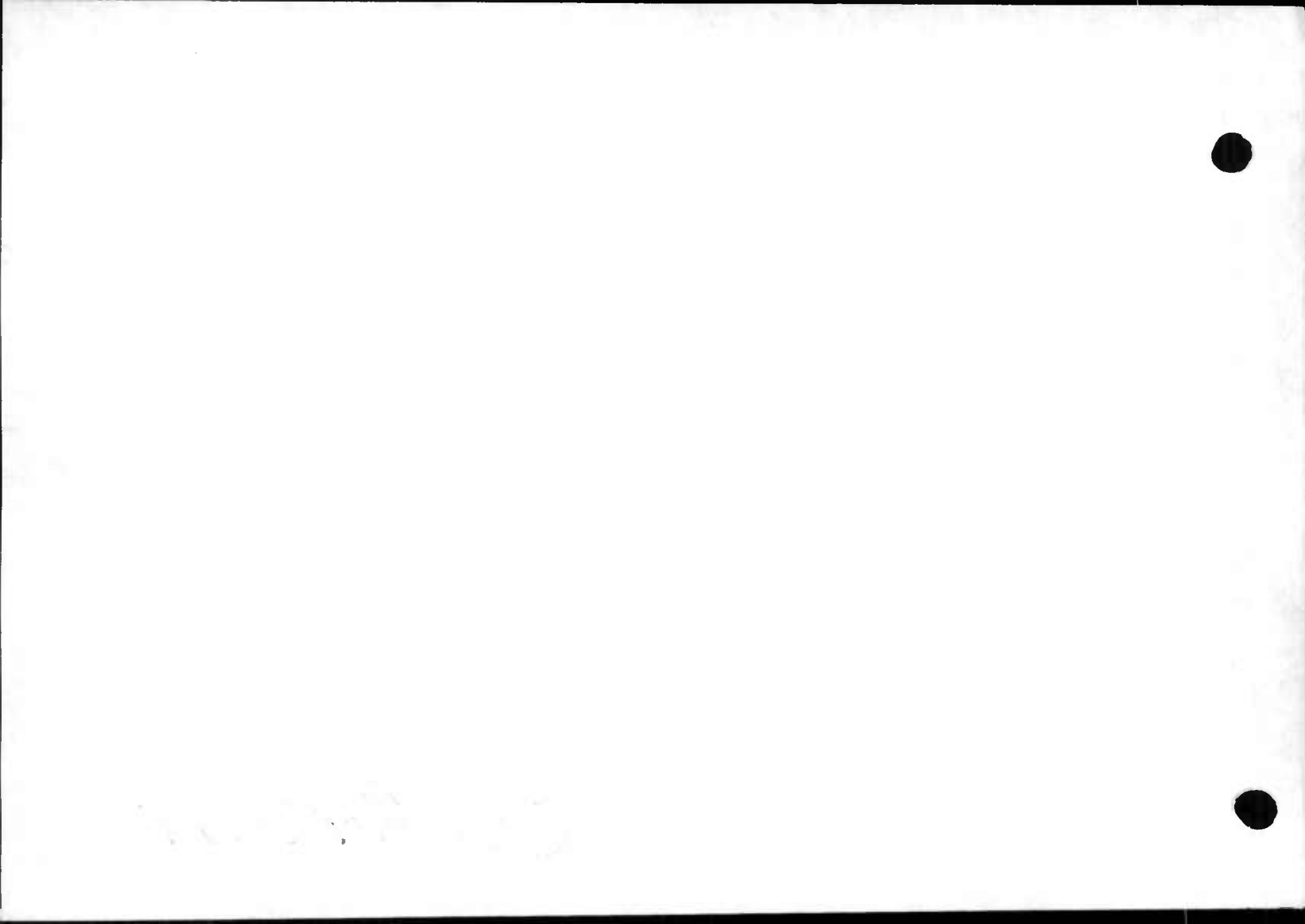
2036 COLTON 41366

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VOID

CERTIFICATE # 86-24004



00-16206

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORT ANT: If item 21 is marked on item 18, show any injury, or other significant event, the medical examiner must be notified.)

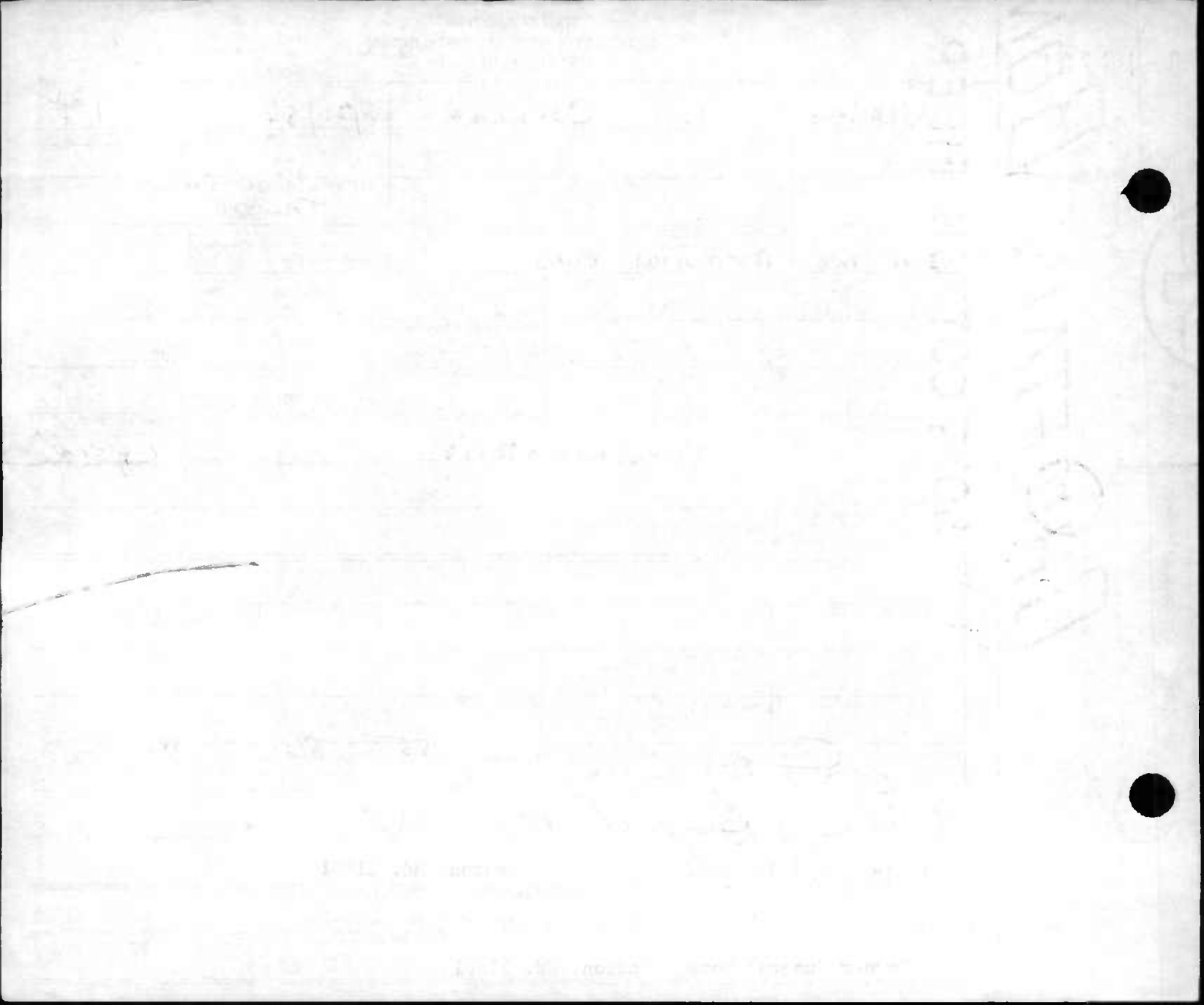
1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24005

1. DECEASED NAME (TYPE OR PRINT) Violet		FIRST H.		MIDDLE CORKRAN		LAST CORKRAN		2a. DATE OF DEATH 8/21/86		MONTH 8		DAY 21		YEAR 86		2b. HOUR 1:25 P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 02 DAY 11 YEAR 13		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD													
10. CITY OR TOWN OF DEATH Easton, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY													
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 415 Salmon Avenue 21601											
14. FATHER'S NAME FIRST William MIDDLE B. LAST Higgins				15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Hunter LAST Hunter															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-52-2365		17. INFORMANT ADDRESS MD Betty F. George 347 Dutchman's Lane Easton															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) this hospital attended the deceased from 8/21 to 8/21 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (2) we (we did) and not view the body after death.																			
22b. SIGNATURE William B. Buziel MD												DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William B. Buziel, M.D.												22e. ADDRESS Easton, Md. 21601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/23/86				23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Pk				23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot MD							
24. FUNERAL DIRECTOR NAME Newnam Funeral Home												ADDRESS Easton, Md. 21601				25a. DATE REC'D. BY REGISTRAR AUG 25 1986		25b. REGISTRAR'S SIGNATURE	

BP



00-15355

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24006  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Luther		MIDDLE HOWARD		LAST Covey		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/>		MONTH DAY YEAR 19		2b. HOUR M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2 12 14		6. AGE (IN YEARS) LAST BIRTHDAY 72 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT		MD		2d. HOUR 14		2e. AM 14	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gen. Route Mgr.		12b. KIND OF BUSINESS OR INDUSTRY Dairy							
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 205 Willis Avenue		21601			
14. FATHER'S NAME FIRST MIDDLE LAST Luther Meriel Covey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Taylor		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 212-22-7884		17. INFORMANT Annabel N. Covey		205 Willis Ave Easton MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>AC-VD</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Louis S. Welch</u>				TITLE (SPECIFY) M.D. <u>pr Dep</u>				MEDICAL EXAMINER				DATE SIGNED <u>8-10-86</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>Louis S. Welch</u>				ADDRESS <u>EASTON Md</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/13/86		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery				23d. LOCATION CITY OR TOWN Easton		COUNTY Talbot	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton MD 21601		25a. DATE REC'D. BY REGISTRAR AUG 13 1986				25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24007

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	HOUR		MIN.
William L. Daugherty			August 26, 1986			5 <sup>30</sup> AM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 25 HRS.
MALE	WHITE	MONTH DAY YEAR FEB. 15, 1903		83 YRS		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND	USA			TALBOT MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
EASTON	EASTON MEMORIAL			CONDUCTOR		RAILROAD		

13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE		
Md			TALBOT	OXFORD		104 RIVERVIEW AVE. 21654		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST William Daugherty			FIRST MIDDLE LAST Florence Darby					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
No			705-10-9422			GLADYS M. DAUGHERTY 104 RIVERVIEW AVE OXFORD, MD 21654		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROSTATE CANCER</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
(b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV</u> 19 <u>85</u> to <u>26 Aug</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>25 Aug</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Stuart C. Cargill</u>		22c. DATE SIGNED <u>8-26-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	AUG. 29, 1986	PARKWOOD	BALTIMORE MD
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
HARTLEY MILLER 7527 HARTFORD RD		AUG 28 1986	
25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

100% COTTON FIBER

DOWN TOWN



THE T. Y. MILLER TEST LABORATORY AND ASSOCIATES

100% COTTON FIBER

0-16570

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24008  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LERoy Brooks EDGAR Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-13-86</b>			2b. HOUR <b>10 5A</b> M					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 9, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.					
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>EASTON MEMORIAL Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6 Shawnee Road 21613</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leroy Brooks Edgar, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Shenton</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>216-14-9537</b>		17. INFORMANT ADDRESS <b>Mrs. Ruth S. Edgar Item # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC LYMPHOCYTIC LEUKEMIA</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 1/3 yrs</b>		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>APR 1983</b> to <b>13 AUG 1986</b> , that (I) (we) last saw the deceased alive on <b>13 AUG 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Stephen P. Carney</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-14-86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen P. Carney, M.D.</b>						22e. ADDRESS <b>Easton, Md. 21601</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8/16/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hurlock, Dor. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Thomas Funeral Home</b>						ADDRESS <b>Cambridge, Md. 21613</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>AUG 18 1986</b> <b>John S. [Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



00-17189

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24009  
REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Jesse		MIDDLE Spry		LAST Forbes		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 8		DAY 31		YEAR 1986		2b. HOUR 8:30 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 08 21 05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 8 31 1986		2d. HOUR 9:45 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD					
10. CITY OR TOWN OF DEATH Easton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospo Easton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boiler Engineer				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland				13b. COUNTY Talbot				13c. CITY OR TOWN Trappe				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST Enoch Haywood Forbes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Gabriel				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 240-12-1048					
17. INFORMANT Gladdie B. Forbes				ADDRESS Rt 1 Box 140 Trappe MD				18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral artery, heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? -								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE R. Lane Wroth, M.D.				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 9-1-86					
EXAMINER'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.				ADDRESS St. Michaels, MD				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/3/86		23c. NAME OF CEMETERY OR CREMATORY Windy Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Trappe Talbot MD	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton MD				25a. DATE REC'D. BY REGISTRAR SEP 5 1986				25b. REGISTRAR'S SIGNATURE Julia Davidson					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25AM

BP  
DHMH - 17  
(VR A15 ME (5))

12 11 21  
10 11 21

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Page

General Information



12 11 21  
10 11 21

General Information

12 11 21

0-81668

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If a medical examiner is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be held.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24010

1. DECEASED NAME (TYPE OR PRINT) <b>Gustav Adolph Frase</b>			2a. DATE OF DEATH MONTH <b>8</b> DAY <b>13</b> YEAR <b>86</b>		2b. HOUR <b>8:5</b> AM
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>July</b> DAY <b>25</b> YEAR <b>1919</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Federalburg, MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot County MD</b>		
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Easton Memorial</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Caroline</b>	13c. CITY OR TOWN <b>Preston</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Rt. 2, Box 284, Preston, Md. 21655</b>	
14. FATHER'S NAME FIRST <b>Gustav Christian</b> MIDDLE <b>Frase</b> LAST <b></b>		15. MOTHER'S MAIDEN NAME FIRST <b>Augusta M.</b> MIDDLE <b>Hintz</b> LAST <b></b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>218-14-2440A</b>	17. INFORMANT ADDRESS <b>Pamela F. Bilbrough, 707 S. 2nd St., Denton, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiomyopathy</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 years</b> <b>many years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>Atrial Fibrillation, Right Pneumonia, Digoxin Toxicity, Ventricular Ectopy</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/11</b> , 19 <b>86</b> , to <b>8/13</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>8-13</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>M. Campagnolo</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>8-14-86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. CAMPAGNOLO, M.D.</b>		22e. ADDRESS <b>P.O. Box 660 Denton Md 21629</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Aug. 16, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Junior Order</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Preston, Caroline MD</b>		
24. FUNERAL DIRECTOR NAME <b>Franklin - Hubbs</b>		25. DATE RECEIVED BY FUNERAL DIRECTOR <b>AUG 21 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Denson-Rodner</b>	

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24011

1. DECEASED NAME (TYPE OR PRINT) <b>MILDRED ELIZABETH GALE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 16 1986</b>		2b. HOUR <b>4<sup>16</sup> M</b>	
1. SEX <b>Female</b>	4. RACE <b>Caucasion</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Apr 30, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TA/bo +</b> MD		
10. CITY OR TOWN OF DEATH <b>EASTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Caro line</b>	13c. CITY OR TOWN <b>Hillsboro</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Everett Hoxter Gale</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Elizabeth Stewart</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219366867</b>		17. INFORMANT ADDRESS <b>Stewart Gale, Denton, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Kidney Longstone Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Recent Onset of Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 wks.</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>RENAL FAILURE</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1/28 86 to 8/16 86</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/15 86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) did not view the body after death.						
22b. SIGNATURE <b>Scott D. Friedman</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/18/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SCOTT D. FRIEDMAN</b>		22e. ADDRESS <b>403 MARVEL COURT EASTON MD 21601</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8/18/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hillsboro Caroline MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>MOORE &amp; FUNERAL HOME &amp; DENTON</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1986</b>				
25b. REGISTRAR'S SIGNATURE <b>Julia Denton-Randall</b>						

WILLIAM E. ...

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00-16436

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24012

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henrietta Cassaway			2a. DATE OF DEATH MONTH DAY YEAR 8 24 86		2b. HOUR 2:55 P.M.	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Feb. 10 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.
7a. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County MD
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY Q.A.		13c. CITY OR TOWN PRICE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Hemsley Downes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Unk.		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-20-6849
17. INFORMANT MRS. LILL E SEWELL		ADDRESS R.F.D. CENTREVILLE, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY J. SPRUIELL		22e. ADDRESS PO Box 210 Queenbury MD 21678				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-28-1986		23c. NAME OF CEMETERY OR CREMATORY M.F.O. Lodge Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE CENTREVILLE Q.A. MD.
24. FUNERAL DIRECTOR NAME Kenneth Wally		ADDRESS CHESTER TOWN MD		25a. DATE REC'D. BY REGISTRAR AUG 27 1986		25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.



2006 ADDITION FIBER

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Alice May Giordano</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 28 86</b>			2b. HOUR <b>12:55 P</b>			
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 24 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b>		7. YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.			
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7 Sunset Lane 21613</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carl L Simmons</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva Estelle Wolf</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-24-4504</b>			17. INFORMANT ADDRESS <b>Carroll Giordano Item #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Eaton's Lambert</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Gray J. Sprinkle</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/2/86</b>	
22e. ADDRESS <b>PO Box 210 Queenstown MD 21657</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/31/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dor. Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dor Md</b>		
24. FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME</b>						ADDRESS <b>CAMBRIDGE, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1986</b>	
						25b. REGISTRAR'S SIGNATURE <b>Julia Anderson-Rublee</b>			

BP



00-14893

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 4 0 1 4

1. DECEASED NAME (TYPE OR PRINT) <b>Edgar W. AYMAN Haddaway SR.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>August 3 1986</b>				2b. HOUR <b>2:40 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 21, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.			
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TAVERN OWNER</b>		12b. KIND OF BUSINESS OR INDUSTRY ----	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>TALBOT</b>		13c. CITY OR TOWN <b>ST. MICHAELS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>209 E. MARENGO ST. 21663</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES FRANKLIN HADDAWAY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HELEEN HADDAWAY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		(IF YES, GIVE WAR OR DATES) <b>WWII</b>		16b. SOCIAL SECURITY NO. <b>214-18-4522AELS</b>		17. INFORMANT <b>SIE J. HADDAWAY</b> ADDRESS <b>209 E. MARENGO ST. ST. MICHAELS, MD. 21663</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the lung with metastases</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 months</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lawrence D. Bohan M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>8-3-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAWRENCE D. BOHAN M.D.</b>				22e. ADDRESS <b>DUTCHMANS LANE EASTON, MARYLAND 21601</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>AUG. 5, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LEE CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON D.C.</b>			
24. FUNERAL DIRECTOR NAME <b>Harmon E. Brown</b>				ADDRESS <b>St. Michaels</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 6 7 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>	

BP





00-17190

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24015  
REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST HERMAN		MIDDLE Edward		LAST HARRISON Jr		2a. DATE KNOWN OF DEATH ESTIMATED Aug. 31 1986		2b. HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 08 20 63		6. AGE (IN YEARS) LAST BIRTHDAY 23 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD Aug. 31 1986		2d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD					
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman		12b. KIND OF BUSINESS OR INDUSTRY Seafood			
13a. STATE Maryland				13b. COUNTY Talbot		13c. CITY OR TOWN Claiborne		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P O Box 37 21624	
14. FATHER'S NAME FIRST MIDDLE LAST Herman Edward Harrison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST F. Irene Floyd				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. 212-76-2467				17. INFORMANT F. Irene Sterling P O Box 282 Queen Anne				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8160 IMMEDIATE CAUSE (a) Fractured Neck. Multiple Head Injuries Due to, OR AS A CONSEQUENCE OF, Auto Accident Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH X				21b. TIME OF INJURY HOUR MONTH DAY YEAR 3:00 PM 8 31 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Drive car went off road					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway		21f. LOCATION Cordova Rt 309, Talbot Md					
22a. I certify that I took charge of the remains described above held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE R. Lane Wroth				M.D. Deputy				MEDICAL EXAMINER DATE SIGNED 8-31-86			
EXAMINER'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.				ADDRESS St. Michaels, MD 21663							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/3/86		23c. NAME OF CEMETERY OR CREMATORY Neavitt Cemetery		23d. LOCATION CITY OR TOWN Neavitt		COUNTY Talbot	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton MD		25a. DATE REC'D. BY REGISTRAR SEP 5 1986		25b. REGISTRAR'S SIGNATURE John T. Anderson			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM 10-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT AND SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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25M

BP  
DHMH - 17  
(VR A15 ME (15))

00-15120

W.A.M.

REPORT OF COMMISSIONER

OF THE

STATE OF



AND

OF THE

LIBRARY

OF THE

STATE OF

MASSACHUSETTS

00-16567

6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24016

1- FOR STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Corinne Holding</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 13 86</b>		2b. HOUR <b>540 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 10, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Florida</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Easton Memorial</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Imp/Exp. Bus.</b>							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Henderson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jesse Milledge Phillips</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jessie Dyer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>266104184</b>		17. INFORMANT ADDRESS <b>Mrs. Ruth Crouse, Denton, MD 21629</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LUNG CANCER</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b>
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>the hospital</del> attended the deceased from <b>7-30</b> , 19 <b>86</b> , to <b>8-13</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>8-13</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen P. Carney</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-14-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen P. Carney, M.D.</b>				22e. ADDRESS <b>Easton, Md. 21601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/15/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Denton Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Denton Caroline MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Moore Funeral Home Denton, Md. 21629</b>							
DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>Aug 18 1986</b> <i>Alia Tucker-Parker</i>							



WILSON  
FIBERS

85338

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

DHMH - 16 60M 7/84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24017

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Dudley R Johnson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 15 86</b>			2b. HOUR <b>11<sup>24</sup> AM</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>May 11 14</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.			7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>			8. IF UNDER 24 HRS HOURS MIN. <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot MD</b>			10. CITY OR TOWN OF DEATH <b>Easton</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Easton Memorial Hospital</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Operator</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Mill</b>					
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Talbot</b>			13c. CITY OR TOWN <b>Easton</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Emery Johnson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Oma Young</b>			16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
17. STREET ADDRESS / ZIP CODE <b>Rt 2 Box 590 21601</b>			18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			19. SOCIAL SECURITY NO. <b>408-18-0595</b>		
20. INFORMANT <b>Fred H Johnson</b>			21. ADDRESS <b>Rt 2 box 602 Easton MD 21601</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEVERE EMPHYSEMA, BRONCHOSPASM</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>EPIDERMAL CARCINOMA OF LUNG, EATON-CAMBERT SYNDROME</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8/15 1986</b> P.M. <b>19</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>81 1086 8/15 86</b>			21g. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot MD</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/15 1986</b> saw the deceased alive on <b>8/15 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.								
22b. SIGNATURE <b>Dr. Fred H Johnson</b>			22c. DEGREE <b>MD</b>			22d. DATE SIGNED <b>8/18/86</b>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Fred H Johnson</b>			22f. ADDRESS <b>403 MARVEL CT. EASTON MD 21601</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8/18/86</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memorial Pk</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot MD</b>			24. FUNERAL DIRECTOR NAME ADDRESS <b>Newnam Funeral Home Easton MD</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 21 1986</b>		
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>								

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

100-15050

215

RECEIVED COLLECTION

NOV 19 1950

NOV 19 1950

00-15689

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 2 4 0 1 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Melvin KEITH, sr.			2a. DATE OF DEATH MONTH DAY YEAR August 16 1986		2b. HOUR 2 58 M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Apr. 13 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Card Grinder		12b. KIND OF BUSINESS OR INDUSTRY Textile Industry
13a. STATE Maryland	13b. COUNTY Talbot	13c. CITY OR TOWN Easton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 105 South Washington St. 21601	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Harrison Keith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-4578	17. INFORMANT ADDRESS 12601 Ida Keith, 105 South Washington St., Easton			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MesoTHELIOMA LEFT PLEURA (LUNG)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1985
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/15/86, 19, to 8/16/86, 19, that (I) (we) last saw the deceased alive on 8/16/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE C. R. W. BARN		DEGREE M.D.		22c. DATE SIGNED 8/16/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. R. W. BARN		22e. ADDRESS Easton, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/19/86	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto. Maryland
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,			ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR AUG 18 1986
					25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP





00-15771

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24019

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Harry J. LAYMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-13-86</b>		2b. HOUR <b>1A M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>06 13 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.	
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Machine Co.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Easton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alfred Cookman Layman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Hinkson</b>		13e. STREET ADDRESS / ZIP CODE <b>300 Prospect Avenue 21601</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-03-7470</b>		17. INFORMANT ADDRESS <b>Valerie L. Youngs 801 High St Easton MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ABDOMINAL AORTIC ANEURISM</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7/1 19 86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>19</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>8/16</b> , 19 <b>86</b> , to <b>8/13</b> , 19 <b>86</b> , that (1) (we) last saw the deceased alive on <b>7/1</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>WS Brem</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/13/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William S BREMER</b>		22e. ADDRESS <b>ST. MICHAELS MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/16/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memorial Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot MD</b>		23e. DATE REC'D. BY REGISTRAR <b>AUG 18 1986</b>			
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>		ADDRESS <b>Easton MD</b>		25b. REGISTRAR'S SIGNATURE <b>Juan Davidson</b>	

BP

1947-48

Table 1

1947-48

1947-48

1947-48

00-16071

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6

REG. NO.

24020

1. DECEASED NAME (TYPE OR PRINT) Ann G. Murphy			2a. DATE OF DEATH MONTH DAY YEAR Aug. 19, 1986		2b. HOUR 12:59 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 06 01 1890		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS
7a. BIRTHPLACE (COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian - The Pines Easton, Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Francis Murphy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bridget Gately		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 098-32-8890
17. INFORMANT ADDRESS Samuel L. Freeland Box 724 Easton MD 21601		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <del>HEART FAILURE</del> Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Years		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (the hospital) attended the deceased from <u>Aug 19 1986</u> to <u>Aug 19 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.						
22a. SIGNATURE William J. Banfield		22b. DEGREE MD		22c. DATE SIGNED 8/19/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William J. Banfield, M.D.		22e. ADDRESS 505 Dutchman's Ln Easton, MD 21601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/22/86		23c. NAME OF CEMETERY OR CREMATORY St Teresa's Cemetery		
23d. LOCATION CITY OR TOWN Summit		23e. COUNTY Union		23f. STATE N.J.		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		24b. ADDRESS Easton MD		25a. DATE REC'D. BY REGISTRAR AUG 21 1986		
25b. REGISTRAR'S SIGNATURE John Davidson-Randall						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Q. 10051

Q. 10051

Q. 10051

00-15769

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24021

1. DECEASED NAME (TYPE OR PRINT) Charles Bartlett MURPHY			2a. DATE OF DEATH MONTH DAY YEAR 8 14 86			2b. HOUR 4:22 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09 27 21		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT County MD			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTON Memorial Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman		12b. KIND OF BUSINESS OR INDUSTRY Seafood	
13a. STATE Maryland				13b. CITY OR TOWN Tilghman		13c. STREET ADDRESS / ZIP CODE Main Street 21671			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Stafford Murphy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Newnan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT June Murphy Main St Tilghman MD 21671				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOpulmonary ARREST 912 DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY ARREST WITH ASPIRATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE Myocardial infarction WITH congestive heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes 25 minutes 8/13/86 (36 hrs)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: END STAGE RENAL DISEASE									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from 8/13 19 86 to 8/14 19 86 that (2) (we) last saw the deceased alive on 8/14 19 86 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above (4) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ludwig J. Eglseider III MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ludwig J. Eglseider III MD				22e. ADDRESS EASTON Memorial Hospital Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8/15/86		23c. NAME OF CEMETERY OR CREMATORY Salisbury Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico MD		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton Md.		25a. DATE REC'D. BY REGISTRAR AUG 18 1986		25b. REGISTRAR'S SIGNATURE Julia Switzer	

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1961

1961

1961

1961



00-15055

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

24022

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wade Hampton Murphy Sr.			2a. DATE KNOWN OF DEATH ESTI-MATED MONTH DAY YEAR 8 7 1986			2b. HOUR M M				
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 11 99	6. AGE (IN YEARS) LAST BIRTHDAY 86 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 7 1986			2d. HOUR IP M	
7a. BIRTHPLACE - (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.				
10. CITY OR TOWN OF DEATH Tilghman		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Main St. Tilghman				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Talbot		13c. CITY OR TOWN Tilghman		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Main St. 21671
14. FATHER'S NAME FIRST MIDDLE LAST James Murphy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Cummings			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-28-6422
17. INFORMANT Wade H. Murphy, Jr.			ADDRESS Box 65 Tilghman MD							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>H.C.-V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		
ACTUAL SIGNATURE Louis S. Welty	TITLE (SPECIFY) M.D. for Dep	MEDICAL EXAMINER DATE SIGNED 8-8-86
EXAMINER'S NAME (TYPE OR PRINT) Louis S. Welty ADDRESS EASTON MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/10/86	23c. NAME OF CEMETERY OR CREMATORY Tilghman Methodist Cem	23d. LOCATION CITY OR TOWN COUNTY STATE Tilghman Talbot MD
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		25a. DATE REC'D. BY REGISTRAR AUG 12 1986	
ADDRESS Easton MD		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. PAGE 5 SHOULD BE FILED WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATION ERIE PA



PAID 10 CENTS



00-15461

Film G618 item 13b,15,17,23d

1- STATE  
FOR 8/25/86 rja  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24023

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Elizabeth P. Nichols</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August, 10, 1986</b>		2b. HOUR <b>4:10 PM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 19 30</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>55</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.	
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DOMESTIC</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>TALBOT</b>		13c. CITY OR TOWN <b>HURLOCK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES OLIVER WEBB</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>REBA Mae HUBBARD</b>		16. STREET ADDRESS / ZIP CODE <b>RT. # 1, BOX 207 B 21643</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <input checked="" type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>213-24-2298</b>		17. INFORMANT NAME ADDRESS <b>REV. CHARLOTTE NICHOLS 420 DOVER STREET EASTON, MD 21601</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SMALL BOWEL OBSTRUCTION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RECURRENT CERVICAL CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 WKS</b> <b>13 YRS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>FEB 83</b> to <b>10 AUG 86</b> , that (I) (we) lost saw the deceased alive on <b>9 AUG 86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Stephen P. Carney</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>8-10-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen P. Carney, M.D.</b>				22e. ADDRESS <b>Easton, Maryland 21601</b>			
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) <b>BURIAL</b>		23b. DATE <b>8-15-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>JOHN'S CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PRESTON TALBOT MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Jolley Memorial Chapel Salisbury, md 21801</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 15 1986</b>			
				25b. REGISTRAR'S SIGNATURE <b>Caroline Talbot</b>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.



0-16217

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24024

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES E. NICKERSON Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 17 86</b>		2b. HOUR <b>735P<sub>M</sub></b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 26 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>
13a. STATE <b>Md.</b>		13b. COUNTY <b>Q.A.</b>		13c. CITY OR TOWN <b>Barclay</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Paul W. Nickerson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith Dhue</b>		16. STREET ADDRESS / ZIP CODE <b>Rt. 1 Box 57 21607</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>215-36-1906</b>		17. INFORMANT <b>Florence M. Nickerson (Same)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage Neck Vessels</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Recurrent Carcinoma Neck</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>July 19 85</b> to <b>Aug 17 19 86</b> , that (I) (we) last saw the deceased alive on <b>Aug 17 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Dr. H W Friedel</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-18-86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR H W. William Friedel</b>		22e. ADDRESS <b>29 CREAMERY Lane Easton Md</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-20-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Templeville Ceme.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Templeville Caroline Md.</b>
24. FUNERAL DIRECTOR NAME <b>Fellows Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John E. Davidson</b>

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remains in the casket. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, entombment, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24025

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Karl Otto</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 14 86</b>		2b. HOUR <b>10<sup>09</sup> A.M.</b>						
3. SEX <b>Male</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-25-07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		8. IF UNDER 24 MRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.					
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital, Easton</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
13a. STATE <b>Md.</b>			13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Marydel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt 1 Box 94B 21649</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick Otto</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara ?</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-76-1354M</b>		17. INFORMANT <b>Emma Reynolds</b>		ADDRESS <b>Marydel, Md. 21649</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Obstructive Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>23.9 years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ASCVD with Atrial fibrillation, CHF</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/14</b> , 19 <b>86</b> , to <b>8/14</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>8/14</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>M. Campagnolo</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-14-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. CAMPAGNOLO, MD</b>						22e. ADDRESS <b>P.O. Box 660 Denton Md 21629</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug. 16, 86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sharon Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dover Kent Del.</b>				
24. FUNERAL DIRECTOR NAME <b>John E. Boulais</b>						ADDRESS <b>Greensboro, Md. 21639</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1986</b>			
						25b. REGISTRAR'S SIGNATURE <b>Julia Dindon-Randee</b>					

BP 1

Yediot

00-17663

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24026

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE KNOWN OF DEATH	
Angela Betty Parker		8 25 19 86 3 10 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
Female	White	5 16 21	65 YRS.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.	
9. CITY OR TOWN OF DEATH		10. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
--- Easton		Easton Memorial Hosp.	
11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12. KIND OF BUSINESS OR INDUSTRY	
PBX Operator		Bd. of Education	
13. STATE		14. COUNTY	
Md.		Talbot	
15. CITY OR TOWN		16. STREET ADDRESS	
Easton		10 Westminister Road 21601	
17. FATHER'S NAME		18. MOTHER'S MAIDEN NAME	
Raymond Christopher McGuire		Hilda Ray Sinnott	
19. WAS DECEASED EVER IN U.S. ARMED FORCES?		20. SOCIAL SECURITY NO.	
No		219-01-6168	
21. INFORMANT		22. ADDRESS	
Mr. Ray Parker		Route 1 E. New Market, Md. - Box 1-Box 180A-1	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Chronic Obstructive Pulmonary Disease			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last			
(b) DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1			
Cerebral Thrombosis			
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
26. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		27. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR	
28. INJURY OCCURRED WHILE AT WORK		29. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
30. I certify that I took charge of the remains described above, held on death resulted from:		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
Natural causes			
Accident			
Suicide			
Homicide			
Undetermined manner			
32. ACTUAL SIGNATURE		33. DATE SIGNED	
J. Paul Wright		8-26-86	
34. EXAMINER'S NAME (TYPE OR PRINT)		35. ADDRESS	
36. BURIAL, CREMATION, REMOVAL (SPECIFY)		37. DATE	
Removal		8-26-86	
38. NAME OF CEMETERY OR CREMATORY		39. LOCATION	
		CITY OR TOWN COUNTY STATE	
40. FUNERAL DIRECTOR NAME		41. DATE REC'D. BY REGISTRAR	
Anatomy Board		SEP 03 1986	
42. ADDRESS		43. REGISTRAR'S SIGNATURE	
Balto., Md.		Julia Tidwell Rader	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

SLIPS

AND

FOR THE

RECORDS



204



00-81641

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24027	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		2b. HOUR	
Warren William Parrish, Jr.								Aug. 31 1986		1:30	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		7. IF UNDER 1 YEAR	
Male		White		August 12, 1915		71 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				TALBOT MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Easton		Easton Memorial		Machinist (Ret)		Hutchison & Sons					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Caroline		Denton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		107 Edenton Lane		21629	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife)		ADDRESS	
Warren William Parrish, Sr.		Grace Mae Snapp		No		218.09.5041		Nannie E. Parrish		Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Massive pulmonary embolism										8-30-86	
DUE TO, OR AS A CONSEQUENCE OF (b) Acute pancreatitis										8-24-86	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 8-24 1986, to 8-31 1986, that (I) (we) lost saw the deceased alive on 8-30 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
Robert W. Truver, M.D.								8-31-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
						RD 3 Box 297 Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
Burial		Sept 3, 1986		Meadowridge Mem. Park		Elkridge		Howard		Maryland	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Singleton Funeral Home Glen Burnie, Maryland						SEP 2 1986		Gordon R. Riddle			

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 4 0 2 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Anna Myra Perry</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 9 86</b>		2b. HOUR <b>10<sup>30</sup> P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>08 07 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.	
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nursing Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Cordova</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Arnold St. 21625</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter K. Sharp</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace Roe</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-74-6089</b>	17. INFORMANT ADDRESS <b>Jack W. Shores 704 E. Dover Rd Easton MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Atrophy with Hydrocephalus</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>ASPD with chronic alcoholism</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/29/86</b> to <b>8/9/86</b> that (I) (we) last saw the deceased alive on <b>7/29/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W. H. Wood</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/11/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William H. Wood, Jr., M.D.</b>		22e. ADDRESS <b>Dutchman's Lane Easton MD 21601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8/12/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot MD</b>	
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>		ADDRESS <b>Easton MD 21601</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 13 1986</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



0-16684

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 24029

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ethel Christina Roberts</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8 23 86</i>		2b. HOUR HOURS MIN. <i>10 45 A</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>08 13 99</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>87</i>	
7a. BIRTHPLACE (STATE OR TERRITORY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD	
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hosp @ Easton</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Nurse</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Medical</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY (LIMITS) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Peter Roberts</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Christina Seidler</i>		16. STREET ADDRESS / ZIP CODE <i>S. Washington St 21601</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>217-30-8612</i>		17. INFORMANT ADDRESS <i>Katharine M. Roberts 207 Crusader Rd Cambridge MD 21613</i>			
18. CAUSE OF DEATH (Enter only one cause per part for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>permanently edema</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>ASCVD - coronary artery disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <i>2 days</i> <i>4 yrs.</i> <i>4 yrs</i>							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Small bowel obstruction</i>							
19a. DATE OF OPERATION <i>8/23/86</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Small bowel obstruction</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY: HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <i>Route 3 Box 127</i>		21g. CITY OR TOWN COUNTY STATE <i>Easton Talbot MD</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/23/86</i> to <i>8/23/86</i> that (I) (we) last saw the deceased alive on <i>8/23/86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.							
22b. SIGNATURE <i>Albert T. Dankins Jr</i>				22c. DATE SIGNED <i>8/23/86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <i>Easton Maryland 21601</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8/26/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Easton Talbot MD</i>	
24. FUNERAL DIRECTOR NAME <i>Newnam Funeral Home</i>				ADDRESS <i>Easton MD 21601</i>		25a. REG. BY REGISTRAR <i>AUG 28 1986</i>	
				25b. REGISTRAR'S SIGNATURE			

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00-16030

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <b>Helen S. Silver</b>					2a. DATE OF DEATH MONTH <b>8</b> DAY <b>16</b> YEAR <b>86</b>					2b. HOUR <b>5</b> PM	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>MAY</b> DAY <b>9</b> YEAR <b>1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.					
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital @ Easton Md</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		
13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>TALBOT</b>		13c. CITY OR TOWN <b>EASTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>528 S. AURORA ST. #21601</b>											
14. FATHER'S NAME FIRST <b>SAMUEL</b> MIDDLE <b>SILVERMAN</b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b>ANNA</b> MIDDLE <b></b> LAST <b>FINESTEIN</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-34-7396</b>		17. INFORMANT <b>MR. RONALD FOX</b> <b>P. O. Box 2103 EASTON, MD 21601</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic Heart Dis</b>										Longstanding	
DUE TO, OR AS A CONSEQUENCE OF											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1968</b> to <b>Present</b> , 19 <b></b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>R. GREGG RHODES MD</b>						DEGREE <b>For Dr. Rhodes</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/17/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. GREGG RHODES MD</b>						22e. ADDRESS <b>503 Ditchman's Lane, Easton, Md 21601</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>AUG. 18, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b>		23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b></b>				
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD</b>						25a. DATE REC'D. BY REGISTRAR <b>21215 AUG 20 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Rendall</b>			

BP





0-81669

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24031

1. DECEASED NAME (TYPE OR PRINT) <i>Bessie AKA BETTY Smedley</i>			3a. DATE OF DEATH MONTH DAY YEAR <i>8/15/86</i>		2b. HOUR <i>4:44 PM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 18, 1921</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i> YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MINS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.		
10. CITY OR TOWN OF DEATH <i>Easton</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Caroline</i>	13c. CITY OR TOWN <i>Federalburg</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>Federal Manor Apts. #703 21632</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank Rogers</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Jane Keiser</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>214-30-8004</i>		17. INFORMANT ADDRESS <i>Wayne Smedley, 5916 Wm. burg Rd, Alexandria, VA</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarct</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hour</i>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)
DUE TO, OR AS A CONSEQUENCE OF		(c)

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>8/15/86 8/15/86</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/15/86</i> to <i>8/15/86</i> , that (we) lost <i>8/15/86</i> above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Thomas Fauntlerox</i>		22c. DATE SIGNED <i>8/16/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>THOMAS FAUNTLEROX</i>		22e. ADDRESS <i>EASTON MEMORIAL HOSP.</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>8-18-86</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Delmarva</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Lewes Sussex Delaware</i>
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24. FUNERAL DIRECTOR NAME ADDRESS <i>Frankton-Hawkins Federalburg, Md.</i>	25. DATE RECEIVED BY REGISTRAR <i>AUG 21 1986</i>
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



0-16685

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24032

1. DECEASED NAME (TYPE OR PRINT) <b>Minnie LEE Smith</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 24 86</b>		2b. HOUR MIN. <b>1045 M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>04 10 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.	
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Aide</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Newcomb</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Granville P. Loudermilk</b>		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Nannie Watts</b>		16. STREET ADDRESS / ZIP CODE <b>Rt 33 Box 22 21653</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>214-20-5838</b>		17. INFORMANT <b>Howard Loudermilk</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BREAST CANCER</b>		DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>5-21</b> , 19 <b>86</b> , to <b>8-24</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>8-15</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stephen Carney</b>		DEGREE <b>PHYSICIAN</b>		22c. DATE SIGNED <b>8-26-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen Carney, M.D.</b>		22e. ADDRESS <b>Easton, Md. 21601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/27/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot MD</b>
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>		ADDRESS <b>Easton, Md. 21601</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 28 1986</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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00-14586

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24033

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DONALD F STAIB				2a. DATE OF DEATH MONTH DAY YEAR 8 02 86		2b. HOUR 4:30 A.M.	
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 5 29 13		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH EASTON, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSP. @ EASTON				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist	
13a. STATE MD		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ludwig A. Staib		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Faber		13e. STREET ADDRESS / ZIP CODE Rt. 5 Box 640 Easton 21601			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-01-3033		17. INFORMANT ADDRESS Anna L. Staib Rt 1 Box 640 Easton MD 21601			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Chronic Obstructive</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>chronic</u> <u>Years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended and deceased from <u>July 27 1986</u> to <u>Aug 1 1986</u> , that (I) (we) lost saw the deceased alive on <u>July 27 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and I) did not view the body after death.							
22b. SIGNATURE <u>PGreco Rhodes</u>				22c. DATE SIGNED <u>8/4/86</u>		22d. ADDRESS <u>503 Ditchman's Lane, Easton, Md 21601</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/5/86		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot MD	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				25a. DATE REC'D. BY REGISTRAR AUG 5 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

*[Faint, illegible handwritten text and markings covering the page]*

00-81746

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24034

1. DECEASED NAME (TYPE OR PRINT) <b>Carolyn Todd</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8/24/86</b>		2b. HOUR P M <b>6:10 P</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 15 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot MD.</b>	
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian - The Pines</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>EDUCATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Wingate</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cornelia N/A</b>		13e. STREET ADDRESS / ZIP CODE <b>701 Church St. 21613</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-34-7263</b>		17. INFORMANT ADDRESS <b>Mr. Phillip Wingate, 1 Somers Lane Del.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Oxygen Brain bleed</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b)	
DUE TO, OR AS A CONSEQUENCE OF						(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Diabetes, Stroke (cerebrovascular accident)</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>7/19/86</b> 19 to <b>8/25/86</b> 19 that (1) was last seen the deceased alive on <b>8/19/86</b> 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>C. W. Bain</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/25/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CALLUM R.W. BAIN, M.D.</b>		22e. ADDRESS <b>14 N. Annapolis St. - Easton, Md. 21601</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-27-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wingate Burial Ground</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wingate, Dorchester, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>CURRAN FUNERAL HOME</b>		ADDRESS <b>308 High St. Cambridge, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 2 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP 1





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24035

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Frances D. Walls</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-5-86</b>		2b. HOUR <b>12:03 PM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 6 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.		
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Ridgely</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Baynard</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katie Coleman</b>		13e. STREET ADDRESS / ZIP CODE <b>207 Caroline Ave 21660</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-32-0245</b>		17. INFORMANT <b>Nathan W. Walls</b>			ADDRESS <b>P. O. Box 745 Ridgely MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } b) <b>dehydration</b> DUE TO, OR AS A CONSEQUENCE OF c) <b>Severe pyloric stenosis + UET 1</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Acute + chronic Antral Ulcer ASCVD Anemia</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>W. H. Webb</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Anne Webb, M.D.</b>				22e. ADDRESS <b>Easton, Maryland 21601</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/8/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Upper Bambury Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Trappe Talbot MD</b>		
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>				ADDRESS <b>Easton MD</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 11 1986</b>		
				25b. REGISTRAR'S SIGNATURE <b>J. Davidson</b>				

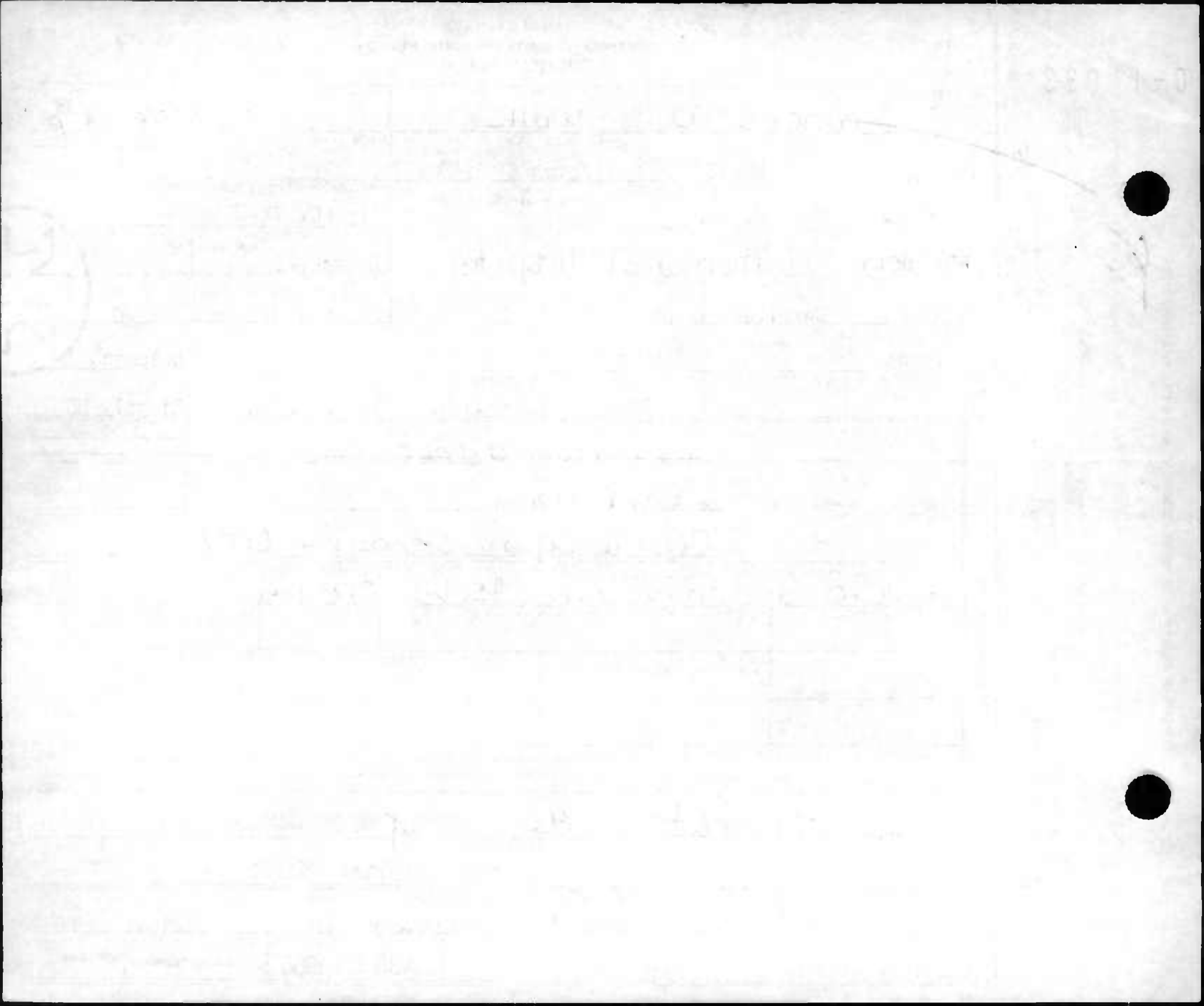
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called in at once.

BP



00-15562

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24036  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Louise C. Walls</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Aug. 9, 86</i>		2b. HOUR <i>12:40 AM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 5, 1919</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>67</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Federalburg, MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>TALBOT</i> MD.	
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial AL</i>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Laundry</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Caroline</i>		13c. CITY OR TOWN <i>Federalburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Clayton E. Covey</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Eva Satterfield</i>		13e. STREET ADDRESS / ZIP CODE <i>516 W. Central Extended, 21632</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-03-8074</i>		17. INFORMANT ADDRESS <i>Orvel Walls, 516 W. Central Ext., Federalburg</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Multiple brain metastases*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) *Carcinoma of the lung*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH} *Uncertain*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

*None*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <i>7-17</i> , 19 <i>86</i> , to <i>8-9</i> , 19 <i>86</i> , that (1) <input checked="" type="checkbox"/> we last saw the deceased alive on <i>8-9</i> , 19 <i>86</i> , and that (2) <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> we did (did not) view the body after death.							
22b. SIGNATURE <i>Robert W. Trever, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8-11-86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert W. Trever, M.D.</i>				22e. ADDRESS <i>RD 3 Box 297 Easton, Md. 21601</i>			

MEDICAL CERTIFICATION

9

1

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8-12-86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Federalburg Caroline MD</i>	
24. FUNERAL DIRECTOR NAME <i>Michael L. Lewis</i>				24. DATE RECEIVED BY FUNERAL DIRECTOR <i>AUG 14 1986</i>			
24. ADDRESS <i>Hampton-Harbison 216 N. Main St. Federalburg, Md. 21632</i>				24. REGISTRAR'S SIGNATURE <i>Julia Dendron-Radner</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 5 completed.

Handwritten notes and markings, including the word "CIBER" and various illegible scribbles.



00-17191

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA-2, OBTAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 4 0 3 1

1. DECEASED NAME (TYPE OR PRINT) <i>Alton Lee Wilson</i>		2a. DATE KNOWN OF DEATH MONTH <i>8</i> DAY <i>29</i> YEAR <i>1986</i>		2b. HOUR <i>11:00</i> AM
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>04</i> DAY <i>19</i> YEAR <i>08</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>78</i> YRS.	7c. DATE PRONOUNCED DEAD MONTH <i>8</i> DAY <i>30</i> YEAR <i>1986</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD	
10. CITY OR TOWN OF DEATH <i>Easton</i>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Caulker</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Boat yard</i>	
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Talbot</i>	13c. CITY OR TOWN <i>Oxford</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>228 South St. 21654</i>
14. FATHER'S NAME FIRST <i>Robert</i> MIDDLE <i>Wilson</i> LAST <i>Wilson</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Ella</i> MIDDLE <i>Robinson</i> LAST <i>Robinson</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>	16b. SOCIAL SECURITY NO. <i>213-16-8409</i>	17. INFORMANT ADDRESS <i>Lottie A. Wilson 228 South St Oxford MD</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drowning</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Substernal Obstruction, Pulmonary Embolism</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR <i>11:00</i> AM MONTH <i>8</i> DAY <i>29</i> YEAR <i>1986</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART FOR PART 2) <i>walked off end of pier.</i>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>	21f. LOCATION STREET <i>South St</i> CITY OR TOWN <i>Oxford</i> COUNTY <i>Talbot</i> STATE <i>Md</i>		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>				
ACTUAL SIGNATURE <i>R. Lane Wroth</i>	TITLE (SPECIFY) <i>M.D.</i>		MEDICAL EXAMINER DATE SIGNED <i>8-30-86</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>R. Lane Wroth, M.D.</i>	ADDRESS <i>St. Michaels, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>9/2/86</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oxford Cemetery</i>	23d. LOCATION CITY OR TOWN <i>Oxford</i> COUNTY <i>Talbot</i> STATE <i>MD</i>	
24. FUNERAL DIRECTOR NAME <i>Newnam Funeral Home</i>		ADDRESS <i>Easton MD</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 5 1986</i>
		25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i>		

07-B4  
25A

BP

DHMH - 17  
(VR A15 ME (5))

1917  
1918  
1919

Wm Lee Wilson

Dearest

Dear Mr. Wilson

I am very glad to hear from you and hope you are well.

Yours truly,  
Wm Lee Wilson